

SUMMERLIN DERMATOLOGY

PATIENT INFORMATION

Date_____

Name:_____

Address:_____

City, State, Zip_____

Phone Number:_____

Sex: M__ F__ Age___ D.O.B._____

Single_Married_Widowed_Separated_Divorced_

SS#(REQUIRED)_____

If the patient is under the age of 18, please fill the following fields.

Guardian Name (if applicable)_____

SS#(REQUIRED)_____

Occupation:_____

Employer:_____

Alternate Phone Number:_____

Whom may we thank for referring you?_____

INSURANCE INFORMATION

Primary Insurance:_____

Group Number:_____

Who is responsible for the account?_____

Relationship to patient:_____

Employer:_____

Employer phone#:_____

D.O.B._____ SS#_____

Secondary Insurance:_____

Group Number:_____

Who is responsible for the account?_____

Relationship to patient:_____

Employer:_____

Employer phone#:_____

D.O.B._____ SS#_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Phone Numbers:_____

Written Acknowledgement of the Receipt of Privacy Practices Notice.

I, (patient name)_____, have received a copy of Summerlin Dermatology's Notice of Privacy Practices.

Signature of patient or parent/guardian
(If under 18, parent/guardian signature is required)

Date

Office Policies—Please Initial each Line

A \$25.00 fee will be charged to your account if:

1. Your check is returned for insufficient funds.
2. Your account is placed with an outside collection agency.
3. You fail to cancel your appointment with the office or our answering service 24 hours prior to your scheduled appointment.

MEDICAL INFORMATION

What is the reason for your visit today? _____

Current Medications:

Allergies:

Medical History:(please check any that apply)

General

- Chills
- Depression
- Fever
- Headache
- Loss of weight
- Numbness
- Sweating

Gastrointestinal

- Poor Appetite
- Bowel changes
- Constipation
- Diarrhea
- Nausea
- Vomiting
- Stomach ache

Eye,Ear,Nose,Throat

- Bleeding gums
- Blurred Vision
- Difficulty Swallowing
- Earache/discharge
- Hoarseness
- Nosebleeds
- Sinus Problems

Men Only

- Penile Discharge
- Sore on Penis
- Other: _____

Women Only

- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- LMP: _____
- Pregnant: Y or N

Urinary

- Blood in the urine
- Frequent urination
- Painful urination

Cardiovascular

- Chest pain
- Irregular/rapid heart beat
- Poor Circulation

Past Medical History:(please check any that apply)

- AIDS
- Arthritis
- Asthma
- Bleeding disorders
- Cancer
- Chemical dependency
- Chicken pox

- Diabetes
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol
- HIV

- Kidney disease
- Liver disease
- Measles
- Pacemaker
- Rheumatic fever
- Scarlet fever
- Stroke

- Thyroid problems
- Tuberculosis
- Ulcers
- Venereal disease

Family History:(please check any that apply to any of your blood relatives)

- Asthma
- Eczema
- Hay fever
- Malignant Melanoma
- Diabetes
- Bleeding disorder

SIGNATURES

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any member of his staff responsible in any way for any errors or omissions that I may have made in the completion of the this form.

Signature: _____

Date: _____